



STATE OF CALIFORNIA  
DIVISION OF WORKERS' COMPENSATION  
WORKERS' COMPENSATION APPEALS BOARD  
COMPROMISE AND RELEASE

ADJ12031731

Case Number 1

Case Number 4

Case Number 2

Case Number 5

Case Number 3

217-25-7160  
SSN (Numbers Only)

**Venue Choice is based upon: (Completion of this section is required)**

County of residence of employee (Labor Code section 5501.5(a)(1) or (d).)  
 County where injury occurred (Labor Code section 5501.5(a)(2) or (d).)  
 County of principal place of business of employee's attorney (Labor Code section 5501.5(a)(3) or (d).)

OAK

Select 3 Letter Office Code For Place/Venue of Hearing (From Document Cover Sheet)

**Employee(Completion of this section is required)**

JONATHAN  
First Name

MI

SHOCKLEY  
Last Name

1000 SUTTER ST 123

Address/PO Box (Please leave blank spaces between numbers, names or words)

SAN FRANCISCO  
City

CA  
State

94109  
Zip Code

**Employer Information (Completion of this section is required)**

Insured       Self-Insured       Legally Uninsured       Uninsured

BIOTELEMETRY INC. DBA CARDIONET LLC

Employer Name (Please leave blank spaces between numbers, names or words)

1000 CEDAR HOLLOW ROAD

Employer Street Address/PO Box (Please leave blank spaces between numbers, names or words)

MALVERN  
City

PA  
State

19355  
Zip Code

**Applicant's Attorney or Authorized Representative:** Law Firm/Attorney Non Attorney RepresentativeZACHARY

First Name

KWELLER

Last Name

7912453

Law Firm Number

PACIFIC WORKERS OAKLAND

Law Firm Name

333 HEGENBERGER RD. STE. 504

Address/PO Box (Please leave blank spaces between numbers, names or words)

OAKLAND

City

CA

State

94621

Zip Code

**Defendant's Attorney or Authorized Representative:** Law Firm/Attorney Non Attorney RepresentativeDOUGLAS

First Name

BURMAN

Last Name

11641868

Law Firm Number

COLANTONI COLLINS FOLSOM

Law Firm Name

444 SOUTH FLOWER STREET SUITE 2150

Address/PO Box (Please leave blank spaces between numbers, names or words)

LOS ANGELES

City

CA

State

90071

Zip Code

**Insurance Carrier Information (if known and if applicable - include even if carrier is adjusted by claims administrator)**CHUBB INDEMNITY INSURANCE COMPANY

Insurance Carrier Name (Please leave blank spaces between numbers, names or words)

PO BOX 42065

Insurance Carrier Street Address/PO Box (Please leave blank spaces between numbers, names or words)

PHOENIX

City

AZ

State

85050

Zip Code

**Claims Administrator Information (if known and if applicable)**

Name (Please leave blank spaces between numbers, names or words)

Street Address/PO Box (Please leave blank spaces between numbers, names or words)

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

**IT IS CLAIMED THAT:**

1. The injured employee, born 09/27/1978 (DATE OF BIRTH: MM/DD/YYYY) , alleges that while employed as a(n)



EKG TECH , sustained injury

(OCCUPATION AT THE TIME OF INJURY)

arising out of and in the course of employment at the locations and during the dates listed below:

(State with specificity the date(s) of injury(ies) and what part(s) of body, conditions or systems are being settled.)

Specific Injury

ADS 12031731

Case Number 1

Cumulative Injury

06/25/2018  
(Start Date: MM/DD/YYYY)

02/15/2019  
(End Date: MM/DD/YYYY)

*(If Specific Injury, use the start date as the specific date of injury)*

Body Part 1: 200 NECK Body Part 2: 315 ARM Body Part 3: 320 WRIST

Body Part 4: 330 HAND Other Body Parts: 340 FINGERS

The injury occurred at JOBSITE

(Street Address/PO Box - Please leave blank spaces between numbers, names or words)

SAN FRANCISCO , CA 94105 .  
City State Zip Code

Body parts, conditions and systems may not be incorporated by reference to medical reports.

Specific Injury

Case Number 2

Cumulative Injury

(Start Date: MM/DD/YYYY)

(End Date: MM/DD/YYYY)

(If Specific Injury, use the start date as the specific date of injury)

Body Part 1: \_\_\_\_\_ Body Part 2: \_\_\_\_\_ Body Part 3: \_\_\_\_\_

Body Part 4: \_\_\_\_\_ Other Body Parts: \_\_\_\_\_

The injury occurred at \_\_\_\_\_  
(Street Address/PO Box - Please leave blank spaces between numbers, names or words)

City \_\_\_\_\_, State \_\_\_\_\_ Zip Code \_\_\_\_\_

Body parts, conditions and systems may not be incorporated by reference to medical reports.

Specific Injury

Case Number 3

Cumulative Injury

(Start Date: MM/DD/YYYY)

(End Date: MM/DD/YYYY)

(If Specific Injury, use the start date as the specific date of injury)

Body Part 1: \_\_\_\_\_ Body Part 2: \_\_\_\_\_ Body Part 3: \_\_\_\_\_

Body Part 4: \_\_\_\_\_ Other Body Parts: \_\_\_\_\_

The injury occurred at \_\_\_\_\_  
(Street Address/PO Box - Please leave blank spaces between numbers, names or words)

City \_\_\_\_\_, State \_\_\_\_\_ Zip Code \_\_\_\_\_

Body parts, conditions and systems may not be incorporated by reference to medical reports.

Specific Injury

Case Number 4

Cumulative Injury

(Start Date: MM/DD/YYYY)

(End Date: MM/DD/YYYY)

(If Specific Injury, use the start date as the specific date of injury)

Body Part 1: \_\_\_\_\_ Body Part 2: \_\_\_\_\_ Body Part 3: \_\_\_\_\_

Body Part 4: \_\_\_\_\_ Other Body Parts: \_\_\_\_\_

The injury occurred at \_\_\_\_\_  
(Street Address/PO Box - Please leave blank spaces between numbers, names or words)

City \_\_\_\_\_, State \_\_\_\_\_ Zip Code \_\_\_\_\_

Body parts, conditions and systems may not be incorporated by reference to medical reports.

Specific Injury

Case Number 5

Cumulative Injury

(Start Date: MM/DD/YYYY)

(End Date: MM/DD/YYYY)

(If Specific Injury, use the start date as the specific date of injury)

Body Part 1: \_\_\_\_\_

Body Part 2: \_\_\_\_\_

Body Part 3: \_\_\_\_\_

Body Part 4: \_\_\_\_\_

Other Body Parts: \_\_\_\_\_

The injury occurred at \_\_\_\_\_  
(Street Address/PO Box - Please leave blank spaces between numbers, names or words)

City \_\_\_\_\_, State \_\_\_\_\_ Zip Code \_\_\_\_\_

Body parts, conditions and systems may not be incorporated by reference to medical reports.

2. Upon approval of this compromise agreement by the Workers' Compensation Appeals Board or a workers' compensation administrative law judge and payment in accordance with the provisions hereof, the employee releases and forever discharges the above-named employer(s) and insurance carrier(s) from all claims and causes of action, whether now known or ascertained or which may hereafter arise or develop as a result of the above-referenced injury(ies), including any and all liability of the employer(s) and the insurance carrier(s) and each of them to the dependents, heirs, executors, representatives, administrators or assigns of the employee. Execution of this form has no effect on claims that are not within the scope of the workers' compensation law or claims that are not subject to the exclusivity provisions of the workers' compensation law, unless otherwise expressly stated.
3. This agreement is limited to settlement of the body parts, conditions, or systems and for the dates of injury set forth in Paragraph No. 1 and further explained in Paragraph No. 9 despite any language to the contrary elsewhere in this document or any addendum.
4. Unless otherwise expressly stated, approval of this agreement RELEASES ANY AND ALL CLAIMS OF APPLICANT'S DEPENDENTS TO DEATH BENEFITS RELATING TO THE INJURY OR INJURIES COVERED BY THIS COMPROMISE AGREEMENT. The parties have considered the release of these benefits in arriving at the sum in Paragraph 7. Any addendum duplicating this language pursuant to Sumner v WCAB (1983) 48 CCC 369 is unnecessary and shall not be attached.
5. Unless otherwise expressly ordered by the Workers' Compensation Appeals Board or a workers' compensation administrative law judge, approval of this agreement does not release any claim applicant may have for vocational rehabilitation benefits or supplemental job displacement benefits.

6. The parties represent that the following facts are true: (If facts are disputed, state what each party contends under Paragraph No. 9.)

EARNINGS AT TIME OF INJURY \$ 956.64

TEMPORARY DISABILITY INDEMNITY PAID 58772.81 Weekly Rate \$ 637.76

Period(s) Paid 03/01/2019 05/13/2022  
(Start Date: MM/DD/YYYY) (End Date: MM/DD/YYYY)

PERMANENT DISABILITY INDEMNITY PAID 17731.43 Weekly Rate \$ 290.00

Period(s) Paid 03/12/2021 End date ONGOING  
(Start Date: MM/DD/YYYY) (End Date: MM/DD/YYYY)

TOTAL MEDICAL BILLS PAID \$ 40478.60 Total Unpaid Medical Expense to be Paid By: DEF THROUGH OACR

Unless otherwise specified herein, the employer will pay no medical expenses incurred after approval of this agreement.

7. The parties agree to settle the above claim(s) on account of the injury(ies) by the payment of the SUM OF

\$ 52000  
Settlement Amount

The following amounts are to be deducted from the settlement amount:

\$ 17731.43 for permanent disability advances through 05/13/2022

\$ \_\_\_\_\_ for temporary disability indemnity overpayment, if any.

\$ \_\_\_\_\_ payable to \_\_\_\_\_

\$ 7800 requested as applicant's attorney's fee.

LEAVING A BALANCE OF \$ 26468.57, after deducting the amounts set forth above and less further permanent disability advances made after the date set forth above. Interest under Labor Code section 5800 is included if the sums set forth herein are paid within 30 days after the date of approval of this agreement.

8. Liens not mentioned in Paragraph No. 7 are to be disposed of as follows (Attach an addendum if necessary):

EDD

DEFENDANTS AGREE TO PAY AND EDD AGREES TO ACCEPT \$1,125.00 IN FULL AND FINAL SATISFACTION OF LIEN ON REFERENCED CLAIM CONTAINED HEREIN.  
INTEREST INCLUDED 30 DAYS. PAYMENT TO BE MADE TO  
DISABILITY INSURANCE OFFICE  
PO BOX 1857  
OAKLAND CA 94604  
TIN 94-2650401

9. The parties wish to settle these matters to avoid the costs, hazards and delays of further litigation, and agree that a serious dispute exists as to the following issues (initial only those that apply). ONLY ISSUES INITIALED BY THE APPLICANT OR HIS/HER REPRESENTATIVE AND DEFENDANTS OR THEIR REPRESENTATIVES ARE INCLUDED WITHIN THIS SETTLEMENT.

Applicant Defendant

DAB earnings

DAB temporary disability

DAB jurisdiction

DAB apportionment

DAB employment

DAB injury AOE/COE

DAB serious and willful misconduct

DAB discrimination (Labor Code §132a)

DAB statute of limitations

DAB future medical treatment

DAB other Mileage; DEATH BENEFITS; P3I

DAB permanent disability

DAB self-procured medical treatment, except as provided in Paragraph 7

DAB vocational rehabilitation benefits/supplemental job displacement benefits

**COMMENTS:**

\*PARTIES HAVE REACHED AGREEMENT, BASED ON REPORTING OF QME DR. STOLLER AND COMPROMISE TO AVOID FUTURE HAZARDS OF LITIGATION, TO SETTLE APPLICANT'S CLAIM OF INJURY, IN ITS ENTIRETY FOR TOTAL SUM OF \$52,000.00.  
\*PARTIES STIPULATE APPLICANT IS ENTITLED TO SDJB VOUCHER.

\*DEFENDANTS WAIVE ANY RIGHT TO TTD OVERPAYMENTS ON FILE.

\*APPLICANT ACKNOWLEDGES THE ADDRESS ABOVE IS TRUE AND CORRECT AND IS WHERE ALL SETTLEMENT PROCEEDS SHOULD BE DELIVERED.

\*APPLICANT ATTESTS THAT HE IS NEITHER CURRENTLY RECEIVING MEDICARE / SSDI, NOR HAS ANY CURRENT EXPECTATION OF RECEIVING SAME WITHIN NEXT 30 MONTHS.

\*THIS COMPROMISE AND RELEASE SETTLES ALL ASPECTS OF THIS CLAIM AND RESOLVES ALL ISSUES RAISED BY THE PLEADINGS, INCLUDING, BUT NOT LIMITED TO ANY AND ALL RETROACTIVE AND/OR ACCRUED BENEFITS SUCH AS TEMPORARY DISABILITY INDEMNITY OR PERMANENT DISABILITY INDEMNITY RETROACTIVE AND/OR ACCRUED BENEFITS, PENALTY AND/OR INTEREST CLAIMS, HOSPITAL, MEDICAL OR PRESCRIPTION EXPENSES, MILEAGE AND/OR PARKING, AND OUT OF POCKET EXPENSES PAID BY APPLICANT. ANY CLAIM FOR PENALTY OR INTEREST IS WAIVED IF PROCEEDS OF THIS SETTLEMENT ARE ISSUED WITHIN THIRTY (30) DAYS OF ORDER APPROVING COMPROMISE AND RELEASE ISSUANCE.

Any accrued claims for Labor Code section 5814 penalties are included in this settlement unless expressly excluded.

10. It is agreed by all parties hereto that the filing of this document is the filing of an application, and that the workers' compensation administrative law judge may in its discretion set the matter for hearing as a regular application, reserving to the parties the right to put in issue any of the facts admitted herein and that if hearing is held with this document used as an application, the defendants shall have available to them all defenses that were available as of the date of filing of this document, and that the workers' compensation administrative law judge may thereafter either approve this Compromise and Release or disapprove it and issue Findings and Award after hearing has been held and the matter regularly submitted for decision.

**11. WARNING TO EMPLOYEE: SETTLEMENT OF YOUR WORKERS' COMPENSATION CLAIM BY COMPROMISE AND RELEASE MAY AFFECT OTHER BENEFITS YOU ARE RECEIVING TO WHICH YOU BECOME ENTITLED TO RECEIVE IN THE FUTURE FROM SOURCES OTHER THAN WORKERS' COMPENSATION, INCLUDING BUT NOT LIMITED TO SOCIAL SECURITY, MEDICARE AND LONG-TERM DISABILITY BENEFITS.**

**THE APPLICANT'S (EMPLOYEE'S) SIGNATURE MUST BE ATTESTED TO BY TWO DISINTERESTED PERSONS OR ACKNOWLEDGED BEFORE A NOTARY PUBLIC**

By signing this agreement, applicant (employee) acknowledges that he/she has read and understands this agreement and has had any questions he/she may have had about this agreement answered to his/her satisfaction.

Witness the signature hereof this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_ at \_\_\_\_\_

|             |        |                        |        |
|-------------|--------|------------------------|--------|
| Witness 1   | (Date) | Applicant (Employee)   | (Date) |
| Witness 2   | (Date) | Attorney for Applicant | (Date) |
| Interpreter | (Date) | Attorney for Defendant | (Date) |
|             |        | Attorney for Defendant | (Date) |
|             |        | Attorney for Defendant | (Date) |
|             |        | Attorney for Defendant | (Date) |

## ACKNOWLEDGMENT

State of California  
County of \_\_\_\_\_)

On \_\_\_\_\_ before me, \_\_\_\_\_  
(insert name and title of the officer)

personally appeared \_\_\_\_\_,  
who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are  
subscribed to the within instrument and acknowledged to me that he/she/they executed the same in  
his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the  
person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing  
paragraph is true and correct.

WITNESS my hand and official seal.

Signature \_\_\_\_\_ (Seal)